MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Friday, September 12, 2003
9:35 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Health insurance markets for Medicare beneficiaries: site visit overview
-- Scott Harrison, Jill Bernstein, Sarah Lowery

MR. HACKBARTH: Our last session in this month's meeting is on health insurance markets for Medicare beneficiaries, a report on some site visits that the staff has conducted.

Who's leading the way?

MS. LOWERY: MedPAC has been examining beneficiaries Medicare supplementation because we know that get beneficiaries rarely have only the basic Medicare package. To further extend our initial analysis of national surveys and administrative data which suggested that there is great variation in the supplemental insurance options both available to beneficiaries and that which beneficiaries choose, MedPAC staff working with Mathematica Policy Research experts conducted site visits in five markets, Long Island, New York, the state of Nebraska, San Diego, California, Atlanta, Georgia, and Minneapolis-St. Paul, Minnesota. Several commissioners actually helped us identify appropriate individuals with whom to speak, and in particular we would like to think Senator Durenberger and Sheila Moroney at the National Institute for Health Policy for all of their help on our site visit to Minnesota.

Altogether we spoke with 155 people, primarily in person but also via telephone in some instances. The site visits have helped us to identify factors that contribute to or pose barriers to the effective functioning of markets for different sorts of insurance products for different beneficiary populations.

A snapshot view of these markets can be seen in this table. In the left-hand column you can see the population of an area, the number of Medicare beneficiaries, the percent of the aged population that is poor, the percent of workers under collective bargaining agreements which can be used as a rough indicator of how prevalent and/or generous their retiree health coverage may be, and Medicare+Choice penetration.

We chose Atlanta because it appeared to have a relatively high percentage of beneficiaries in Medicare fee-for-service only and relatively low percentages of Medigap, Medicare managed care, and employer-sponsored retiree coverage. We selected Long Island because it appeared to have a high percentage of employer-sponsored supplemental coverage and New York State has guaranteed issue and community rating requirements for Medigap plans.

Minnesota is a Medigap waiver state, meaning it has products other than the standard A through J plans, and the Twin Cities have high Medicare managed care penetration much of which is in cost plans. San Diego has a very high M+C enrollment and a high concentration of military retirees who have recently gained access to a new generous supplemental insurance program, the TriCare for Life program. Nebraska is a rural state and has very high Medigap penetration.

Now I'll turn it over to Scott who will provide more details

on Medicare supplemental insurance options in the sites.

DR. HARRISON: I'm going to describe some of the salient features of the first three of the five markets that we visited and I'm going to try to abbreviate this because I know that we're running late.

Long Island, which we've defined here as Nassau and Suffolk Counties has experience a steep decline in the number of M+C options available over the last several years. There are now two plans serving the area down from eight, and the penetration has dropped from 20 percent in 2000 down to 12 percent now. Plans that have pulled out of Long Island, we think primarily have pulled out because of lower M+C payment rates on the island compared with neighboring New York City. Medicare fee-for-service spending on the island is similar to most parts of the city after you take out the GME, but the payment rates are $70 to $240 per month lower than those in the five boroughs. Nassau and Suffolk rates do appear to be about $30 per month under the fee-for-service spending in this counties.

Those plans that still serve Long Island charge premiums of over $100 per month and offer generic-only drug benefits while there are zero premium plans with better benefits in the city. To make this problem more uncomfortable, beneficiaries on Long Island see all of the New York City TV ads where the managed care companies in the city are advertising all the great benefits that they can get, then they call up and find out, sorry, not for you.

For other kinds of coverage, the New York metropolitan area is heavily unionized and there's quite a difference in retiree coverage among the public unions and those people who work for private companies.

In the Medigap market, insurers are required to community rate for the disabled as well as the elderly and open enrollment is required. Offerors appear to have adapted to these requirements and view them as creating a level playing field. However, when these requirements first came in they were not pleased.

However, there aren't limited Medigap offerings on Long Island. There are 11 companies offering the most basic Medigap plan. Premiums start at about $80 per month and there's only three insurers that offer a drug plan and none of them offer a Plan J. Some New Yorkers can get drug coverage in another way. The state operates the very popular Elderly Pharmaceutical Insurance Coverage or EPIC program. Medicare beneficiaries are eligible if their incomes are $35,000 or less. There's premiums on a sliding scale and fixed copays for drugs.

As far as the general provider structure on Long Island, hospitals generally have consolidated into -- not generally, they really have almost totally consolidated into two systems and each contracts as a group. Physicians typically practice individually or in small groups. Provider risk-sharing is limited. The plans they no trouble creating networks of physicians but they have trouble getting hospital discounts.

Let's move to Nebraska. Since 1999 there's been only one M+C plan in Nebraska run by United and it serves only the Omaha area. United has recently also added a non-demonstration PPO in

Omaha. Both of those, the HMO and the PPO are zero premium products with no drug coverage. The HMO also has a high option available and that does include generic drug coverage and the premium there is $71 per month.

Outside of Omaha, Nebraska beneficiaries can enroll in two private fee-for-service plans. The premiums there go from $9 to $88. Neither of those plans offers a drug benefit. They haven't been much of a factor. The two plans together have enrolled fewer than 150 beneficiaries in the state.

Medigap is by far the most common source of supplemental coverage in Nebraska. Over half of Medicare beneficiaries in the state have supplemental coverage through a Medigap plan. Thirty-five Medigap insurers offer products, although only four offer any of the prescription drug plans. The plans start around $50 a month at age 65 and only two Plan J's are available and they start at around $200. There's no guaranteed issue for the under-65 disabled in Nebraska, and there's only one plan listed on the CMS -- by the way, all the Medigap data and number of insurers I'm getting off the CMS web site. There's only one listed that provides products to the disabled and it offers only a Plan A or B.

As far as employer coverage in the area, it's very low due to the lack of large businesses and unions in the state. The state government itself does not offer retiree health coverage to Medicare-eligible retirees. Those individuals with employer-sponsored coverage have had to fund more of that coverage out-of-pocket. Employer contributions have decreased. The take-up rates have stayed fairly high, and primarily because these plans are sometimes the only way for retirees to get reasonably priced drug coverage.

MR. HACKBARTH: Scott, can I just intervene for a second? I'm worried that we're going to lose the remaining commissioners, so if I could, I'd ask you to take a little bit different tack here and focus on the cross-cutting gains that as I look at your presentation, are page 10 and there after, as opposed to the individual market detail.

DR. HARRISON: That's fine. I'll turn it over to Jill then to do that.

DR. BERNSTEIN: Our contractor, Mathematica Policy Research is currently drafting a report covering all of the site visits. We're working with them and we've identified a number of themes and those are what we wanted to talk about for the most part today anyhow.

First, even though everything that we've read suggested there was a problem with employer-sponsored retiree coverage, we were not ready for what we saw on the site visits. Small and midsize employers simply were not offering coverage, and even some of the large employers are moving toward plans in which retirees pay the full premium. That is, employers will arrange for group plans for people but they're not contributing for retirees after they hit the age of 65 in many of the places we visited including a couple of states. Nebraska and Minnesota state employees don't have any contribution made toward their retiree health coverage. University systems are moving away from

it, and hospital systems are not offering any retiree health coverage.

There are certain exceptions in certain industries and some of the public sector places, including the state of Georgia. But we think we need to spend more time doing additional work to understand the implications of cutbacks in retiree health coverage for Medicare, for beneficiaries and for other insurance products.

Second, a lot of what's happening across all the supplemental types of insurance, Medigap, M+C, employer-sponsored, and Medicaid is driven by the cost of prescription drugs. One of the factors shaping the group market and employers willingness to organize group products even when they don't contribute to the premiums is the ability to craft drug programs for employees that are not available in the individual market.

So we want to look more closely at how existing drug coverage works or doesn't work and different kinds of insurance arrangements, M+C, M+C group contracts, Medigap options under select plans, under generic-only options like the ones we found being marketed in California and some other states under the H, I, J plans, and under waiver systems like Minnesota which offers a different kind of drug benefit and is picked up by a much larger proportion of people than the Medigap options in the states under the NAIC rules.

Third, even though Medigap and M+C options operate under federal rules, state regulators and state oversight remain important. We want to focus more attention on the implications of things like guaranteed issue and open enrollment as they affect the current playing field, and what sorts of federal preemption issues might come into play if new insurance products become available either through incremental changes or through broader policy changes.

A related theme also came up. From the perspective of many of the people we talked to, some of what has involved, some of what states and organizations have worked hard to put into place seems to be working pretty well. Notable examples are the EPIC program in New York, the popular Integrated Care System serving beneficiaries in Minnesota as well as the state's Medigap system, or the managed care system in San Diego. People there are worried that changes in policy could undo what they've put in place and replace it with something that might not work as well.

Three more quick issues. In previous reports we raised some issues regarding meeting beneficiaries' needs with different kinds of insurance and bolstering beneficiaries' ability to make good choices in a complicated set of choices. Site visits provided additional food for thought. These markets offered different kinds of choices at different prices. One constant, however, was the cost of supplementation can be very high and it's out of reach for some beneficiaries. In some markets, insurers and plans have responded with new lower-cost products, often with high deductibles.

Advocates raise some serious questions about the extent to which beneficiaries understand the increasingly complicated choices that they have, and in particular whether they understand

the low-cost options that are being marketed. We also heard a lot from providers, plans and beneficiary advocates about perceived with the way Medicare and other payers pay for care. There's a lot of variation in M+C payment rates across these areas which affects benefits and premiums. There's variation in the payment rates to providers under fee-for-service which affects Medigap rates, and there's variation in the ways that these rates compare to each other across these areas.

As you know, in some places we visited the M+C rates are significantly lower than they are in other area of the country which plans and beneficiaries see as unfair. In two markets where we visited people, in San Diego and Minneapolis, providers and plans believe that managed care penetration was a major factor shaping the health-care delivery patterns resulting in lower utilization and therefore lower M+C rates. But it's also important to note that in some of the other places we went, Long Island is an exception but it's generally true in the other sites, M+C rates are actually higher and in some places significantly higher than they would be if the plans were paid at the fee-for-service level in those areas.

The site visits weren't designed to provide nationally representative data on payment policy and these issues probably should be input for other follow-up work that we will do and collaborate with our colleagues on. But we think it's important as context that virtually everyone we talked to is convinced that some aspect of Medicare payment is unfair, although the reasoning varies from place to place. I think that's a very important context.

Finally, the way that provider organizations are structured, the extent to which different groups of providers can or have incentives to create networks or negotiate rates clearly affects the market for supplemental insurance products. This work has helped us to identify as kind of a typology to help us to explain how different insurance products have evolved or will likely evolve in the future. This could help us identify how policy changes when they're overlaid on these different kinds of markets might play out.

So where we're going is we're going to get you a draft report to talk about at the next meeting. We're going to have a final report by the end of the year, hopefully sooner. And other aspects of this work will be integrated into work that we plan to do for the March report, in particular looking at what's going on in M+C PPOs in particular. And in the June report we want to focus more heavily on what's going on with employer-sponsored retiree health benefits.

With that, we will take your input.

MS. BURKE: I think these are exactly the right questions to ask. It obviously doesn't need to be said that the passage of a drug bill will presumably throw a great deal of this into -- in terms of understanding what the impact is. I don't know how you plan to accommodate that, but I guess what I wouldn't want to have is us appear to have produced something with no sense of what's going on in the rest of the world. But I'm assuming as you go forward and as we look at this, some suggestion as to what

the impact might be of a broader benefit would at least be noted in reference in terms of the analysis that would have to be done.

MR. HACKBARTH: Any others?

DR. WAKEFIELD: I stepped out, so my apologies, I probably missed this. On your follow-on work, leading up to why this follow-on work as it's listed here, any reason why Medigap is not up there?

DR. BERNSTEIN: No, Medigap will be covered.

DR. WAKEFIELD: In one of those two reports.

DR. BERNSTEIN: It will definitely be covered in the main report.

MR. HACKBARTH: Okay, thank you.